1.0 Department of Health - Medical Assistance

Summary

Medical Assistance is a joint federal/state entitlement service consisting of three programs that provide health care to selected low-income populations: (1) a health insurance program for low-income parents (mostly mothers) and children (nationally, about 40 percent of all births are covered by Medicaid); (2) a long-term care program for the elderly (nearly 70 percent of all nursing home residents are Medicaid beneficiaries); and (3) a funding source for services to people with disabilities (Medicaid pays for approximately one-third of the nation's bill for this population). Nationwide, Medicaid covers over 36 million people, or about 13 percent of all Americans and nearly half of those living in poverty.

Overall, Medicaid is an "optional" program, one that a State can elect to offer. However, if a State offers the program, it becomes an entitlement program for qualified individuals; that is, anyone who meets specific eligibility criteria is "entitled" to Medicaid services. The federal government establishes and monitors certain requirements concerning funding, and establishes standards for quality and scope of medical services. States have some flexibility in determining certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits, and service delivery.

The federal and state governments share the costs of providing Medicaid services. For program administration, the federal government covers 50 percent of the costs in each state. For the medical services provided under the program, the federal medical assistance percentage (FMAP), or matching rate, varies among states, based on per capita income. In general, states chose to participate in Medicaid because of the substantial financial incentives from the federal government to assist in the costs of health services for people who otherwise would not be able to pay.

Utah is one of the 49 states that has a Medicaid Program. The Medicaid line item consists of three programs: the Medicaid Base Program, Title XIX Seeding for the Department of Human Services, and the Utah Medical Assistance Program (UMAP). The first two programs are based on the availability of federal funds under Title XIX of the Social Security Act, while UMAP is funded with State funds only. For FY 2000, the FMAP for programs qualifying under Title XIX is 71.64, a decrease from last year's FMAP of 71.98 percent. The FMAP at 71.64 percent means that for each Medicaid dollar of expenditure, the

State provides 28.36 cents, with the federal government picking up the remaining 71.64 cents. The State utilizes various funding streams (dedicated credits and restricted funds) to make up its share.

The United States Congress has explored various reforms to Medicaid and Medicare. During 1996, major welfare reform was enacted which has implications on Medicaid, but additional changes that have been discussed and are still in the future could significantly change the Medicaid program in Utah as well as all of the other states. However, in order to prepare and propose a Medicaid budget to the 1999 Legislature, the Analyst is basing his recommendations on current rules and regulations.

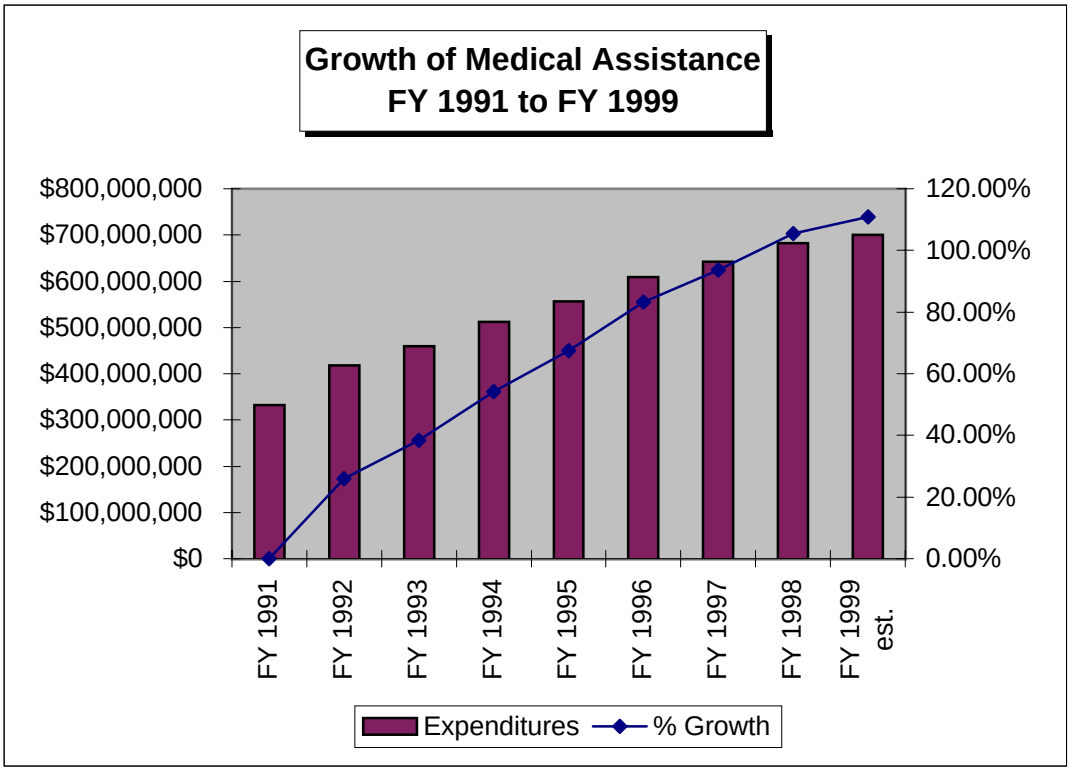
The Medicaid Base Program is the program most commonly identified with Medical Assistance. The FY 1999 base program makes up almost 85 percent of all Medical Assistance expenditures. The Medicaid Base program provides a number of services to specific eligible populations. While much of the program is currently mandated by federal law and regulations, there are some state options and waivers which allow the state some latitude in program implementation. The federal government has considered several major changes to these requirements, with "block grants" being the one most discussed. Block grants would allow more flexibility to the state in determining its Medical Assistance recipients and benefits.

Legislation was approved several years ago, which imposes an assessment on nursing facilities, then utilizes those funds as the "State" funds in order to draw down, or match the federal funds at the nearly three-to-one match rate. (A similar assessment, imposed on hospitals, again to draw down additional federal dollars, was ended last year.)

Title XIX Funding for the Department of Human Services consists of programs and services provided by the Department of Human Services to individuals who qualify for the Medicaid services. The State's share of the funding is from the General Fund appropriated to the Department of Human Services, which is then transferred to the Medicaid program.

The Utah Medical Assistance Program (UMAP) is a State program designed to provide a very limited number of services to a population that does not qualify for any other medical assistance.

The Analyst's total recommendation for FY 2000 represents an increase of 4.42 percent over estimated FY 1999 expenditures. The following chart shows the growth in expenditures for Medical Assistance from FY 1991 through FY 1999.



The Analyst recommends a total budget for Medical Assistance for FY 2000 of $731,460,400. The General Fund portion of the recommendation is $145,626,500.

Medicaid Restricted Account

One of the other sources of funding is the Medicaid Restricted Account. This account was established to capture any excess funds from the Medicaid program and keep them in a separate, nonlapsing account, for ". . . programs that expand medical assistance coverage and private health insurance plans to low income persons who have not traditionally been served by Medicaid, including the Utah Children's Health Insurance Program created in Chapter 40." (UCA 26-18-402)

Funds from an assessment on hospitals for the Children's Health Insurance Program (CHIP) beyond that which is needed to fund the CHIP may be used for the Medicaid program (26-40-112). The Analyst shows those excess funds going back into the Medicaid Restricted Account in the CHIP budget, and uses funds from that account for the Medicaid program here.

The balance in the Medicaid Restricted Account, at the end of FY 1999, will be approximately $16.3 million plus accrued interest.

Financial Summary

	FY 2000
Plan of Financing	**LFA**
General Fund	$145,626,500
Federal Funds	512,675,700
Dedicated Credits	32,582,100
GF Rest. - Medicaid Restricted Account	5,588,700
GF Rest. - Nursing Facility Account	4,042,900
Revenue Transfer	30,944,400
Total	**$731,460,300**
Programs	
Medicaid Base Program	$621,353,100
Title XIX Funding for Human Services	103,321,300
Utah Medical Assisstance Program	6,785,900
Total	**$731,460,300**

2.0 Budget Highlights: Department of Health - Medical Assistance

2.1 Federal Match Rate Change

The match rate which the Federal government uses to determine the amount of funds it will provide to the State has decreased the past several years. For FY 2000, it is projected to decrease by 0.34 percent, from 71.98 percent to 71.64 percent. This translates into a General Fund need of $1,748,100 to maintain the program at the current level. Other funding sources are utilized to reach a total amount of $1,895,900 in total lost Federal funds.

2.1 Funding

	FY 2000
Plan of Financing	**LFA**
General Fund	$1,748,100
Federal Funds	(1,895,900)
Dedicated Credits	74,700
GF Rest. - Medicaid Restricted Account	21,600
GF Rest. - Nursing Facility Account	51,500
Total	**$0**
FTE	

2.2 Medicaid Inflation and Caseload Growth

Projected inflation and increased utilization together create the need for additional funding of almost $30 million for FY 2000, of which $7,025,800 is from the General Fund. Inflation and utilization are both federally-mandated issues.

2.2 Funding

	FY 2000
Plan of Financing	**LFA**
General Fund	$7,025,800
Federal Funds	21,472,300
Dedicated Credits	335,500
GF Rest. - Medicaid Restricted Account	1,000,000
GF Rest. - Nursing Facility Account	152,500
Total	**$29,986,100**
FTE	0.00

2.3 Increased Caseload in Medicaid Children due to CHIP Outreach

Last year, the Legislature approved the new Children's Health Insurance Program (CHIP). Due to outreach efforts to enroll children on the CHIP, Medicaid-eligible children have been found. When a child is deemed Medicaid eligible, that child cannot enroll in CHIP, but may enroll in the Medicaid program. This funding covers the anticipated 3,500 Medicaid-eligible children.

2.3 Funding

	FY 2000
Plan of Financing	**LFA**
Federal Funds	$3,150,700
Dedicated Credits	49,200
GF Rest. - Medicaid Restricted Account	1,200,000
Total	**$4,399,900**
FTE	0.00

2.4 Technology-Dependent Children - UNFUNDED -

There are currently 32 children who are on a waiting list for services under the Travis C waiver, which covers medically-fragile, technology-dependent children. The General Fund amount to cover these children is $163,700, and total funding is $600,000. This is an unfunded recommendation.

2.4 Funding

	FY 2000
Plan of Financing	**LFA**
General Fund	$163,700
Federal Funds	429,600
Dedicated Credits	6,700
Total	**$600,000**
FTE	

Summary Budget Highlights Funding (Funded Items Only)

	FY 2000
Plan of Financing	**LFA**
General Fund	$8,773,900
Federal Funds	22,727,100
Dedicated Credits	459,400
GF Rest. - Medicaid Restricted Account	2,221,600
GF Rest. - Nursing Facility Account	204,000
Total	**$34,386,000**
FTE	0.00

3.1 Medical Assistance - Medicaid Base Program

Recommendation

The Analyst recommends an appropriation of $586,967,100 for the Medicaid Base Program for FY 2000. The recommendation requires $133,593,700 from the General Fund, which, with the other sources of revenue, is matchable by Federal funds in the amount of $413,497,200. The Analyst's total recommendation is $3.7 million below the FY 1999 estimated level. This reduction is the result of the termination of the temporary assessment on hospital providers. The reduction of that funding source, together with the Federal funds that were drawn down as a match, result in the reduction.

The figures show the FY 1999 use of one-time funds from the Medicaid Restricted Account in the amount of $3,439,000.

The Analyst projects collections from the Nursing Facility Assessment to generate approximately $400,000 less in FY 2000 than in FY 1999.

All of the funding for the Medicaid Base program is used to pay claims for services provided to recipients by health care providers. There are no expenditures in the Medicaid Base budget for personal services (FTEs), travel, current expenses, or capital equipment.

3.1 Funding

Plan of Financing	FY 1998 Actual	FY 1999 Estimated	FY 2000 LFA	Difference Est./LFA
General Fund	$130,085,600	$133,593,700	$133,593,700	$0
Federal Funds	405,347,736	414,642,600	413,497,200	(1,145,400)
Dedicated Credits	32,173,717	33,799,800	32,122,700	(1,677,100)
GF Rest. - Medicaid Hospital Provider Temporary Assessment Account	6,335,900	0	0	0
GF Rest. - Medicaid Restricted Account	1,750,000	3,439,000	3,367,100	(71,900)
GF Rest. - Nursing Facility Account	3,681,700	4,244,800	3,838,900	(405,900)
Revenue Transfer	823,721	823,700	547,500	(276,200)
Beginning Non-Lapsing	0	134,500	0	(134,500)
Closing Non-Lapsing	(134,529)	0	0	0
Lapsing	(8,042,375)	0	0	0
Total	**$572,021,470**	**$590,678,100**	**$586,967,100**	**($3,711,000)**
% Change		3.26%	(0.63%)	
FTE	0.0	0.0	0.0	0.0

Summary

The Medicaid Base Program consists of the expenditures for approved services for eligible people. It is a joint state/federal program which provides health care, as established under Title XIX of the Social Security Act. Many of the program parameters are established in federal law and regulations.

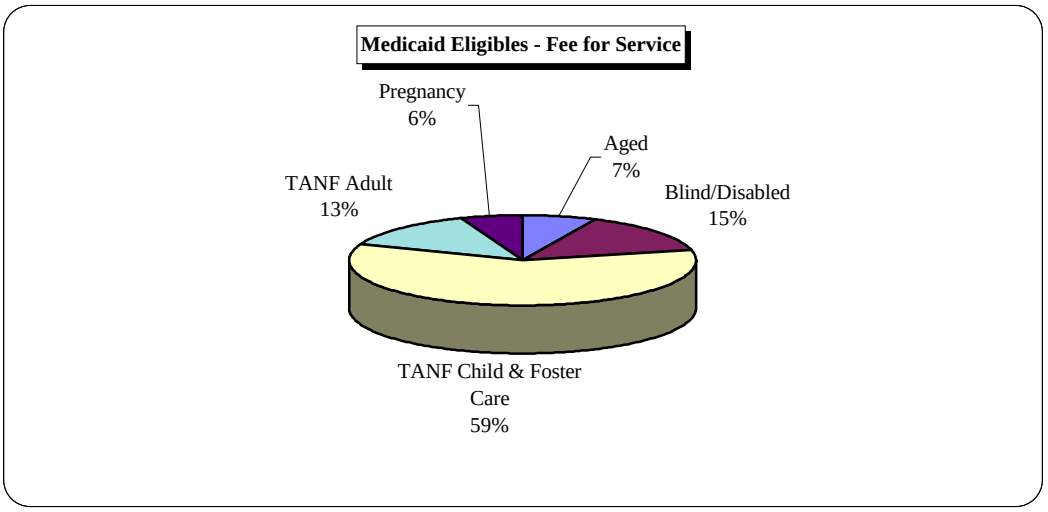
Much of the effort in the Medicaid program recently has been toward moving eligibles who live in the populated Wasatch front counties from the traditional "fee for-service" to managed care, or health maintenance organizations (HMOs). The purpose behind this effort is to provide more cost-effective health care. The cost savings are earmarked for the expansion of coverage proposed in HealthPrint.

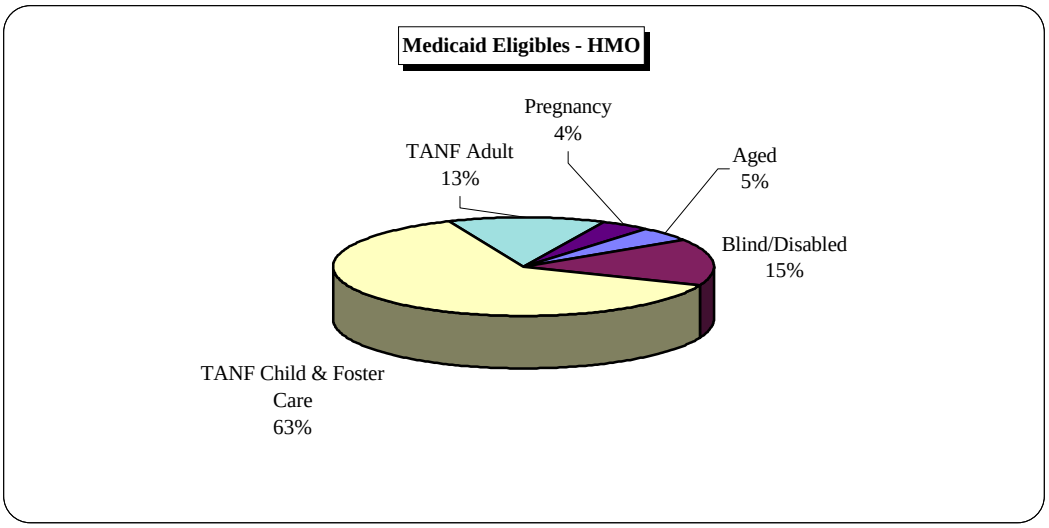
As a result of this movement, data is collected differently than in the past, blurring historical trends. In some portions of this analysis, both fee-for service and HMO data will be shown.

The state has designated five major population groupings who may receive health care from the Medicaid program. These include: (1) the elderly who receive federal SSI and persons in nursing facilities (grouped together as **Aged**); (2) **Blind or Disabled** individuals; (3) Children who receive **Temporary Assistance for Needy Families (TANF)** benefits, or are in the Foster Care program; (4) **TANF Adults**, with dependent children; and (5) **Pregnant** women. Each of these groups is discussed in more detail later in this section.

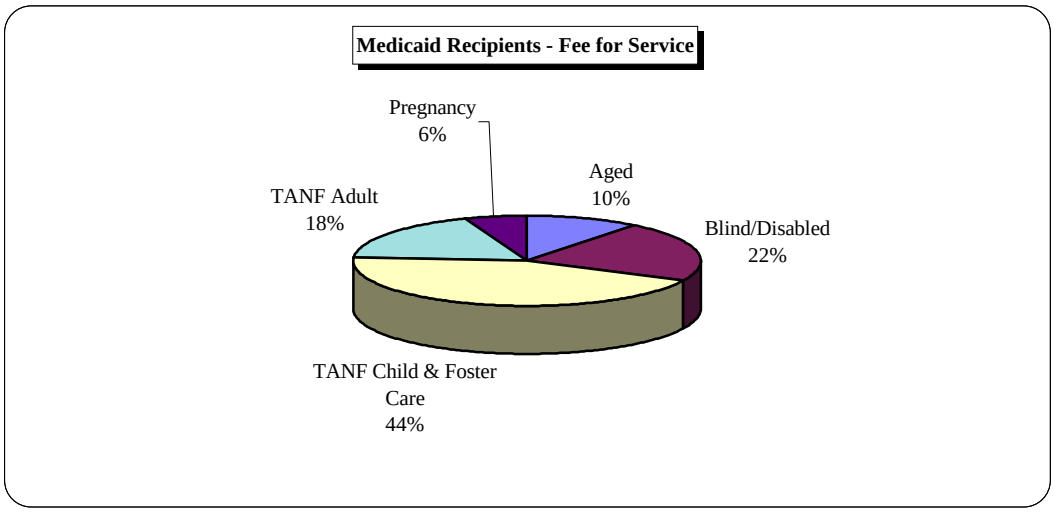
The distribution of eligible people, recipients, and expenditures for each group are shown in the following charts.

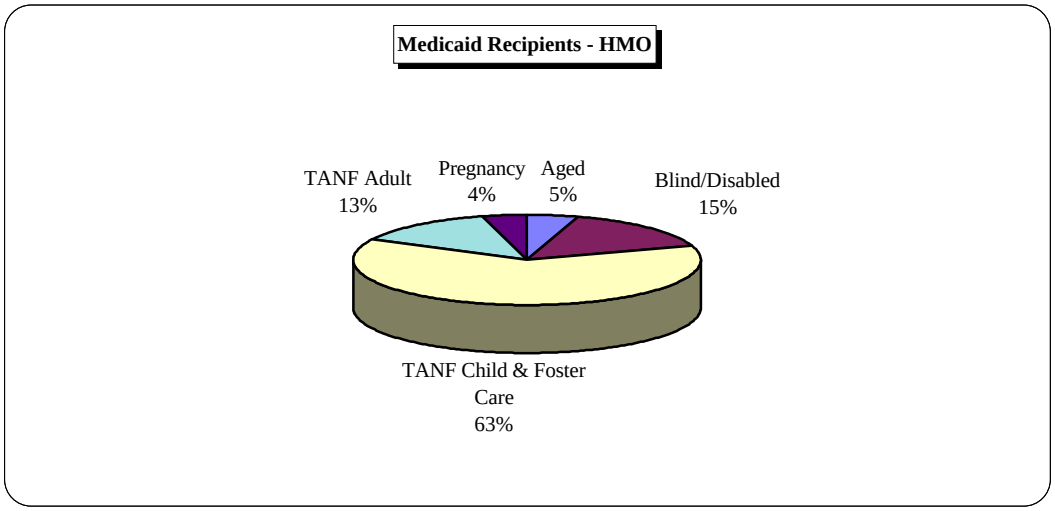
Medicaid Eligibles



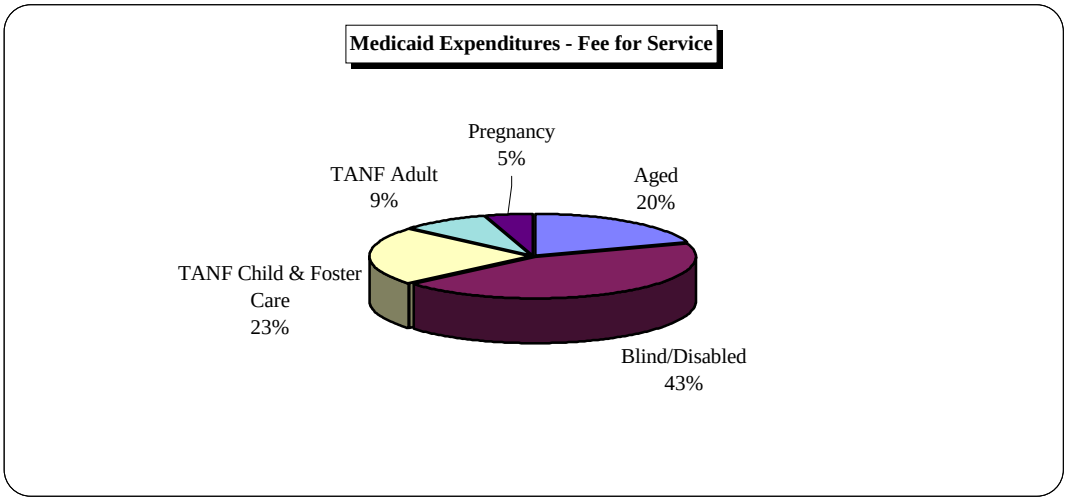


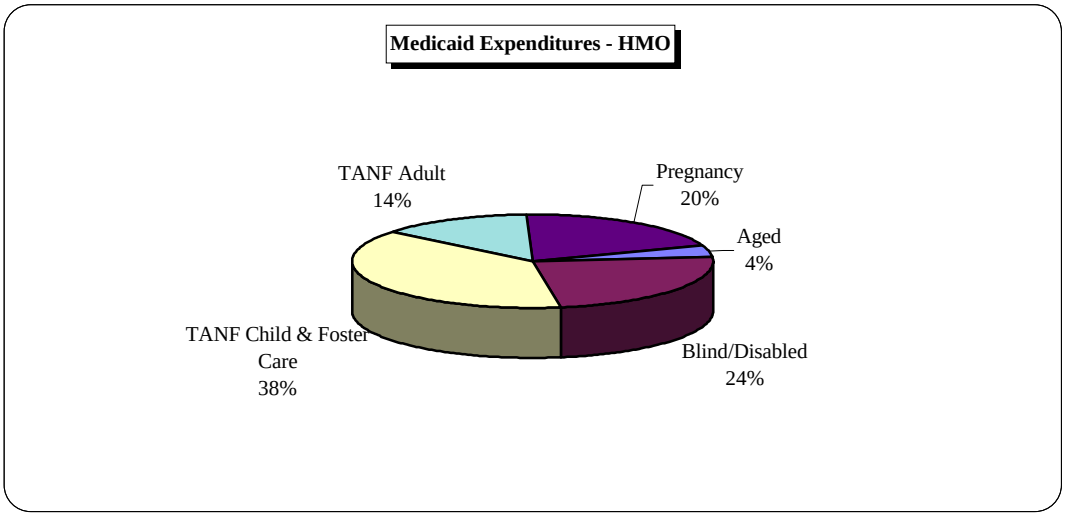
Medicaid Recipients





Medicaid Expenditures





Medicaid Services

There are currently 45 services included in the Medicaid Program. Of these, inpatient hospital, outpatient hospital, intermediate care facilities for the mentally retarded, long term care, physician, dental, pharmacy, and health maintenance organizations make up approximately 66 percent of program expenditures. The line dividing mandatory and optional services is occasionally blurred by the fact that some optional services are mandatory for specific populations or in specific settings. A brief description of each service is found in Section 4.2.

Mandatory Services

Mandatory services in the Medicaid Program include: inpatient and outpatient hospital, physician, skilled and intermediate care nursing facilities, medical transportation, home health, nurse midwife, pregnancy-related services, lab and radiology, kidney dialysis, Early Periodic Screening Diagnosis and Treatment, and community and rural health centers. The State is also required to pay Medicare premiums and co-insurance deductibles for aged, blind, and disabled persons with incomes up to 100 percent of the poverty level. (Medicaid pays the premiums for individuals between 100 and 135 percent. Medicaid is also required to pay a benefit of $1.07 per month for Medicare beneficiaries with incomes between 135 and 175 percent of poverty. This change is due to a federal mandate and is 100 percent federally funded).

The Early Periodic Screening Diagnosis and Treatment Program is a mandatory program which requires the State to screen all Medicaid children at scheduled intervals. The mandate includes all medically necessary services, such as organ transplants or any other service needed, regardless of cost.

Optional Services

Optional Services still qualify for the same FMAP, but do require approval from the federal Health Care Financing Administration (HCFA). These include pharmacy, dental, medical supplies, ambulatory surgery, chiropractic, podiatry, physical therapy, vision care, substance abuse treatment, speech and hearing services. The only optional long-term care is Intermediate Care Facilities for the Mentally Retarded. As noted above, some of these services may be mandatory for certain populations or in certain settings. It should also be noted that while the service, as a whole may be optional, once the state elects to offer that service, it must make it available to all qualified eligibles.

Funding of Medicaid

Since Medicaid is a joint State/federal program, the federal government provides a portion of the funding to administer and implement the program. The federal share is based on the state's per-capita income and is recomputed annually. Since Utah has a relatively low per-capita income, the federal portion is higher than most other states. However, since the State has experienced economic prosperity the past several years, per-capita income has increased, and this has translated into a decrease in the federal match rate. The federal share of Medicaid expenditures was 74.58 percent in FY 1994, and annually has experienced small percentage drops since. It is projected to be 71.61 percent for

FY 2000. To maintain the program at a consistent level, those lost federal funds need to be replaced. Each year, the Legislature has funded this loss of federal funds by increasing the General Fund allocation. For FY 2000, the Analyst projects the General Fund requirement will be $1,748,100. Other funding sources can be utilized to reach the total projected federal funds loss of $1,895,900. This is simply a switch in the funding ratio and does not expand the level of services or increase the number of recipients covered.

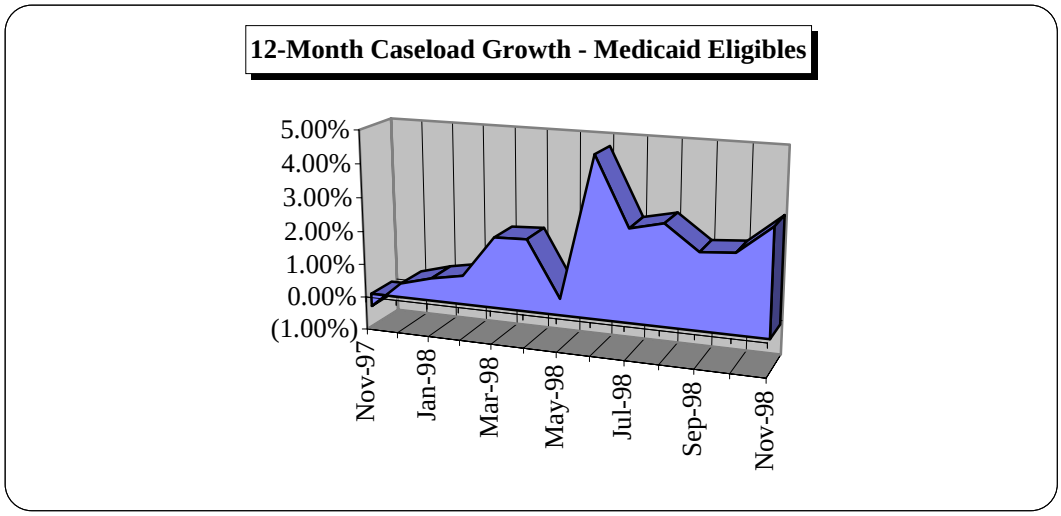
Inflationary Increases

The Analyst has included inflationary increases for Hospital Services, HMOs, Nursing Home Facilities, Ambulatory Surgical Centers, Community Health Centers, and Pharmacies, as required by law. The total inflationary increase built into the Analyst's recommendations averages 4.08 percent and is estimated at $19,933,000 with $4,784,000 coming from the General Fund.

Caseload Growth and Utilization Increases

The Analyst's recommendation also includes funding to cover caseload growth and increases in utilization. The recommended amount for FY 2000 is $10,053,100, of which $2,241,800 comes from the General Fund. The past few years has seen a slow down in the growth rate for Medicaid eligibles. However, the trends of the past several months indicate an upswing in Medicaid caseloads. In addition to caseloads, utilization factors influence the increases included here. Utilization factors consider the number of times a recipient receives a Medicaid service.

As stated above, the monthly reports show an overall growth rate in number of eligibles of about 3 percent. The following chart shows the month by month growth rate for all Medicaid eligibles.



A few years ago, the Federal government required states to add children under age 18 and under 100 percent of the Federal Poverty Level (FPL) at the rate of at least one age group per year. The 1994 Legislature elected to approve funding for the entire group of Medicaid eligible children up to the age of 18 all at once. Currently, all children under age 18 and under 100 percent of the Federal Poverty Level are considered eligible. (CHIP covers the same age group of children from 100 percent to 200 percent of poverty).

The 1998 Legislature increased funding for FY 1999 for the Medical Assistance budget to cover the reduction in the Federal funds match rate and for inflation and utilization. However, with the loss of the Temporary Hospital Provider Assessment and the corresponding federal funds, the FY 1999 appropriation was actually $18.2 million below the FY 1998 estimated level of expenditures.

Intent Language

The Legislature included the following intent language in the FY 1999 Appropriations Acts for Medical Assistance:

> *It is the intent of the Legislature that the Department of Health will review with the Interim Executive Appropriations Committee any Medicaid Program reductions or additions.*

Response

No program reductions or additions were noted.

Health Care Reform

One of the effects of the current debate over health care reform is that there is a trend toward more managed care. Current State Medicaid rules require recipients living on the Wasatch Front to be enrolled in a health maintenance organization (HMO). It is estimated that approximately 97 to100 percent of Medicaid clients living on the Wasatch Front are now enrolled in a HMO. Approximately 66 percent of the same Medicaid population was enrolled in a HMO during 1995.

Federal Poverty Level

Eligibility for many of the new Medicaid Programs, which Congress has added in recent years, is based on a person's income relative to the federal poverty level. The table on the following page shows the federal poverty levels for 1998 by family size. The table also shows 133 percent of poverty because coverage for pregnant women is mandatory for persons with incomes up to 133 percent of poverty. Currently the State has the option of raising eligibility for programs for pregnant women and children to 185 percent of poverty.

1998 FEDERAL MONTHLY POVERTY LEVELS

Family Size	100%	Annualized	133%	185%
1	$671	$8,050	$892	$1,241
2	904	10,850	1,203	1,673
3	1,138	13,650	1,513	2,104
4	1,371	16,450	1,823	2,536
5	1,604	19,250	2,134	2,968
6	1,838	22,050	2,444	3,399
7	2,071	24,850	2,754	3,831
8	2,304	27,650	3,065	4,263
9	2,538	30,450	3,375	4,694
10	2,771	33,250	3,685	5,126
each additional person	233	2,800	310	432

Aged

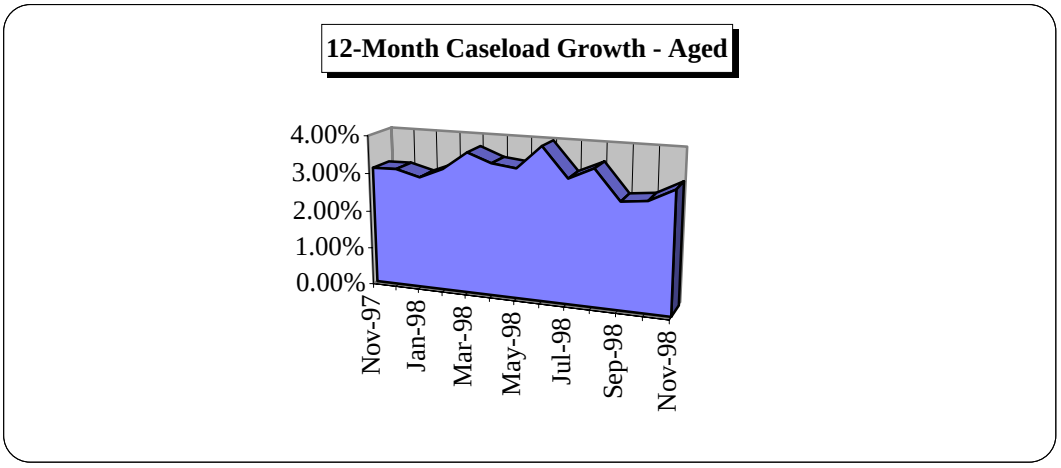
Individuals aged 65 and over qualify for Medicaid if they qualify for the Federal Supplemental Security Income Program, which provides an income of approximately 77.6 percent of poverty. They also qualify for food stamps. During FY 1998, there was an average number of 11,800 people eligible under the aged category of eligibility. Many of the elderly also qualify for Medicare coverage. The Medicaid Program pays for the premiums and deductibles for those eligible under both programs. Medicare pays the actual medical cost for most of these people. The largest expenditure for the elderly is for pharmacy items, which are not covered under Medicare. Medicaid is also required to pay Medicare premiums, co-insurance, and deductibles for anyone qualifying for Medicare who has income up to 100 percent of poverty, but Medicare premiums only for those between 100 and 135 percent of poverty.

Medicaid also covers non-SSI aged people whose income does not exceed 100 percent of poverty. Aged people with income over 100 percent of poverty can spenddown to the Medically Needy Income Limit to receive Medicaid.

In July 1986, there were 5,794 nursing facility beds in the State. The census was 5,034 for an occupancy rate of 87 percent. Medicaid paid for 71 percent of all occupants. Since that time, the number of beds has increased 31 percent to 7,592 with a current occupancy rate of 77.5 percent.

A Medicaid waiver has been obtained by the Division of Aging which will allow Medicaid to pay for some services in home and community-based settings. This is diverting some elderly people from nursing facility care.

The following chart shows the growth rate for the aged and nursing home categories from November 1997 through November 1998.



Blind and Disabled

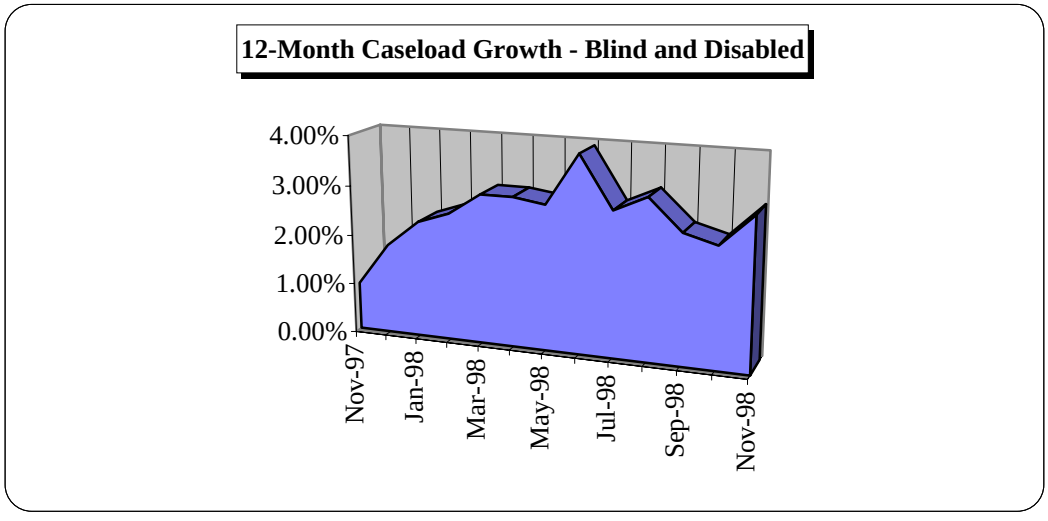
Persons receiving assistance due to blindness have always been part of the Medicaid Program. The number of blind adults in November 1998 was 60 and the number of children was 8.

Persons with disabilities are also eligible for services under the Medicaid Program. The number of disabled adults in November 1998 was 15,168 and the number of disabled children was 2,979, for a total of 18,147. Criteria for disability requires that a person be unable to participate in gainful employment for at least a year, or have a medical condition that will result in death. Among the disabilities covered are: mental retardation, mental health, spinal injury, and AIDS. Income is limited to 73.5 percent of the federal poverty level for blind individuals and 100 percent for disabled individuals. An asset test similar to that for AFDC is required. Eligible individuals also qualify for food stamps.

The Blind and Disabled make up almost 15 percent of the Medicaid eligible population, while accounting for 18 percent of recipients. In FY 1998, they accounted for 39 percent of total Medicaid expenditures. Institutional care for disabled individuals is included in this category . The chart on the following page shows the 12-month growth rate for the combined Blind and Disabled categorical group.

A special group of nursing facilities are Intermediate Care Facilities for the Mentally Retarded (ICF/MR). These facilities specialize in the care of people with disabilities. The populations served by ICFs/MR are in need of more continuous supervision and structure, but are not significantly different from those served in other systems serving people with disabilities. ICFs/MR are long-term care programs certified to receive Medicaid reimbursement for habilitative and rehabilitative services and must provide for the active treatment needs which are met in a community environment. Nursing services are available for those requiring nursing and medical services.

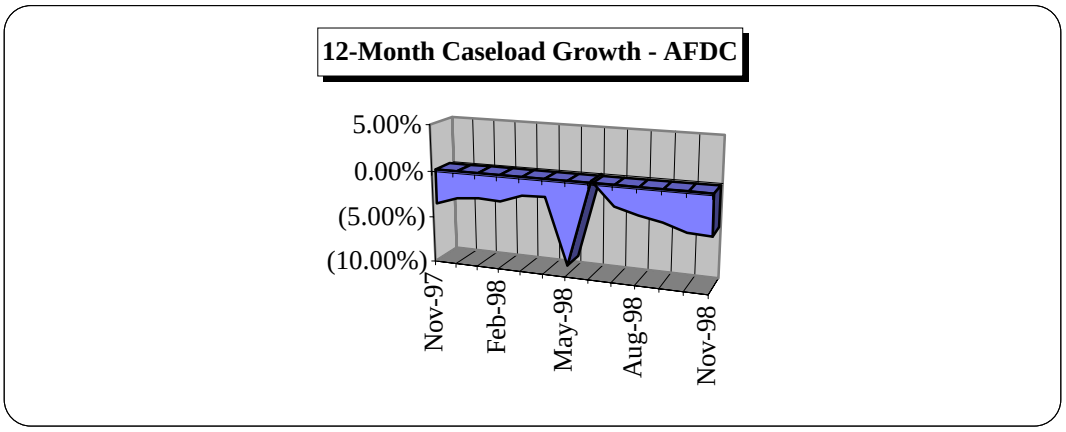
There are specific federal regulations requiring active treatment programs and other treatment options. Current State law limits the size of new ICF/MR facilities to 16 beds or less. There are currently 13 privately-owned facilities with populations ranging from 12 to 83 and one State ICF/MR facility (the Utah State Developmental Center (USDC)) licensed for 390. Only three of the facilities meet the 16-or-fewer bed standard. ICFs/MR are an optional service in the Medicaid Program. Occupancy in the ICFs/MR is currently near 98 percent. The industry suggests that many of the vacant certified beds are not available due to the conversion of space to meet federal active treatment standards. The average cost per client in an ICF/MR for FY 1998 was approximately $42,340, which is a full-service program (including a residential, day program, transportation, and medical services).



Temporary Assistance to Needy Families (TANF) and Foster Care

Aid to Families with Dependent Children (AFDC) was a joint federal-state program which provided financial assistance to families with children deprived of the support of at least one parent. On August 22, 1996, President Clinton signed the welfare reform bill, which ended the Aid to Families with Dependent Children (AFDC) entitlement program and replaced if with block grants to the states and the Temporary Assistance to Needy Families (TANF) program. In general, however, people who meet AFDC eligibility criteria that were in effect on July 16, 1996 will be eligible for Medicaid. Also, those people who qualify for a TANF grant are eligible for Medicaid.

There are two groups of people who qualify for Medicaid under the TANF program. These include: (1) those in the basic program where a child is deprived of the support of one parent, and (2) those in two-parent families that qualify under the unemployed parent program. The TANF programs account for approximately 60 percent of all eligible persons in Medicaid, 53 percent of Medicaid recipients, and 26 percent of total expenditures. The following chart shows the 12-month caseload growth rate for the TANF population. The chart shows that this segment of the Medicaid program has actually lost cases during the past year.



Over 90 percent of eligible families are deprived because of divorce, desertion, or unwed mothers. TANF families may also qualify for food stamps. Depending on family size, the AFDC grant and food stamps provide between 62 and 74 percent of the federal poverty level. There is an asset limit of $2,000 for families in the TANF program. The asset limit does not include a residence or a car with an equity value of less than $8,000. The average monthly number of TANF eligibles during FY 1998 was 118,316.

In addition to the basic Family Employment Program (FEP), there is also a program for unemployed two-parent families. This program provides cash assistance for seven months in any 13-month period. One parent in families in this program is required to work 32 hours a week (in an emergency work program) and spend at least 8 hours a week seeking regular employment. With the exception of the time limitation and work requirement, the criteria and benefits for the Family Employment Program - Two Parent (FEP-TP) are the same as those for the regular FEP. Federal law requires that the family be eligible for Medicaid for the full 12 months of the year. Besides those eligible through FEP cash assistance, there are several programs which provide transitional Medicaid coverage for periods of 4 (for child support-related eligibles) or 24 months for people who no longer receive cash assistance due to child support payments or earnings. Approximately 31 percent of the people who spend down to qualify for Medicaid come under the FEP category of eligibility. This portion of the FEP continues to grow. This likely is the result of self-sufficiency efforts in the FEP which have increased the number of people receiving transitional benefits.

Children in Foster Care are eligible for Medicaid coverage if they meet Medicaid program requirements. The State is responsible for their medical care. The coverage is optional for Medicaid, but if not covered, the State would be responsible for the full cost of care. Most children placed in foster care have histories of abuse or neglect. This often means there are unresolved medical and mental health problems which must be dealt with.

In addition to the previously mentioned TANF children, there are four groups of children covered under the Medicaid Program. These are (1) medically needy children, (2) children under age 6 with family income up to 133 percent of poverty, (3) children and youth between age 6 and 18 with income up to 100 percent of poverty, (4) children in subsidized adoptions.

The Medically Needy Children program is for children who do not qualify for assistance under normal Family Medicaid because they are not deprived of the support of a parent. The asset test is the same as for TANF; the income test is the same as for the Blind and Disabled, and the family is allowed to spend down to become eligible. This is an optional group, meaning it is not required by the federal government, and so coverage could be terminated. Many children who have been eligible for this group in the past have become eligible in the mandatory programs for children.

The program for children under age six with family income up to 133 percent of poverty is a mandatory program. The program for children born after September 30, 1983 with family income up to 100 percent of the poverty level is designed to provide coverage for children in poverty. The 1994 and 1995 Legislatures approved funding to cover the entire group of children, up to age 18. There is an asset test required for children in this category of $3,000 for a family of two; one home is exempted, and a car with an equity value of $1,500 is allowed.

Each year, a number of children come into the custody of the State and are placed for adoption. Some of these children have serious medical or other problems which makes them hard to place. In some of these cases, the State subsidizes the adoption. Some families receive a small stipend to assist in the cost of care for these children, and the State covers the child's medical care under Medicaid until the child is 18 years old.

TANF Adults

The group referred to as TANF Adults includes those adults with dependent children who are either categorically or medically needy. Any adult who qualifies for a financial payment through the FEP, qualifies for Medicaid as a TANF Adult. Some of the individuals may be required to "spenddown" to obtain their Medicaid card, which means that they must reduce their spendable income with payments to Medicaid or with medical bills which they have incurred.

Pregnancy

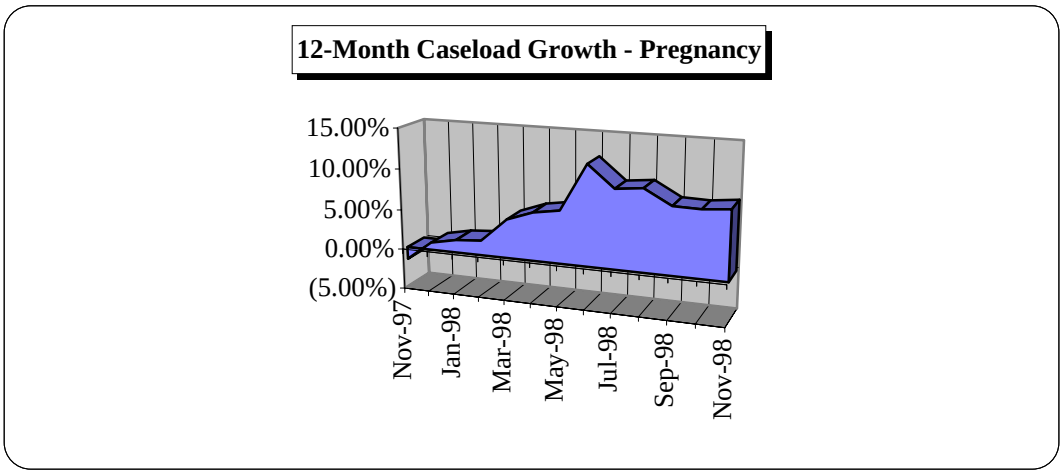
The prenatal/pregnancy program helps pregnant women receive prenatal care. The program covers the mother from the time of application to 60 days after the birth. A woman only needs to meet the eligibility requirements in any one month to be eligible for the entire pregnancy. Children born to women on this program can be covered on Medicaid (after the first 60 days) for the rest of the first year under the postnatal program.

Approximately one-third of all babies born in the State are paid for by Medicaid. This has been the case for the past few years.

Of the mothers in the program, approximately 23 percent are eligible under the FEP program, and 72 percent were eligible through the Pregnancy Program. Other mothers are eligible through other programs such as emergency medical care, blind or disabled, medically needy children, and foster children.

At the beginning of 1998, the Pregnancy Program had a caseload of approximately 12,059. During 1998, the caseload increased for most of the year. By the end of the year, the caseload had grown to 12,700.

The chart on the following page shows the fluctuations in the number of cases for the pregnancy program from November 1997 to November 1998.



Utah Tomorrow

The following Utah Tomorrow performance measures are affected by the decision to fund interpretive services in the Medicaid program:

Performance Measure	1990	1995	2000
Percent of local health departments that offer translating services.			
Percent of private providers who have translation services available for their clients			

3.1 Budget Highlights: Medicaid Base Program

Federal Match Rate Change, Inflation, Utilization

Recommended increases to the Base Medicaid program include funding for the funding mix change due to the reduced federal match rate, inflationary increases, utilization, and caseload growth increases. The greatest factor in this recommendation covers inflationary costs ($19.9 million). The Analyst recommends a total of $29,986,100, with $8,773,900 from the General Fund.

	FY 2000
Plan of Financing	**LFA**
General Fund	$8,773,900
Federal Funds	19,576,400
Dedicated Credits	410,200
GF Rest. - Medicaid Hospital Provider Temporary Assessment Account	1,021,600
GF Rest. - Nursing Facility Account	204,000
Total	**$29,986,100**
FTE	0.00

New Medicaid Children

Due to the outreach efforts for the CHIP, it is anticipated that approximately 3,500 new children will be located and enrolled in Medicaid. This increase of $4,399,900 will fund those children on the Medicaid program.

	FY 2000
Plan of Financing	**LFA**
Federal Funds	$3,150,700
Dedicated Credits	49,200
GF Rest. - Medicaid Restricted Account	1,200,000
Total	**$4,399,900**
FTE	0.00

Technology-Dependent Children - UNFUNDED -

There are 32 children who qualify for Medicaid services under the Travis C. waiver for technology-dependent children, but the waiver is limited to 50 children at any one time. The waiver allows families an option to keep their medically fragile child at home and still receive needed care and services. Additional funding will allow the 32 children similar services to the 50 already being served under the waiver. The Analyst unfunded recommendation is a total increase of $600,000, of which $163,700 is from the General Fund.

	FY 2000
Plan of Financing	**LFA**
General Fund	$163,700
Federal Funds	429,600
Dedicated Credits	6,700
Total	**$600,000**
FTE	

3.2 Medical Assistance - Title XIX Funding for Human Services

Recommendation

The Analyst recommends an appropriation of $103,321,300 for the Title XIX funding for services provided by the Department of Human Services. This funding level is the same as the FY 1999 estimated levels. There is no General Fund in this appropriation.

3.2 Funding

Plan of Financing	FY 1998 Actual	FY 1999 Estimated	FY 2000 LFA	Difference Est./LFA
Federal Funds	71,696,432	74,370,700	74,370,700	0
Revenue Transfer	31,624,820	28,950,600	28,950,600	0
Total	**$103,321,252**	**$103,321,300**	**$103,321,300**	**$0**
% Change		0.00%	0.00%	
FTE	0.0	0.0	0.0	0.0

Summary

It has been the historical policy of the Legislature to have the Department of Human Services maximize federal funds. One of the ways this has been done is through accessing Medicaid for Human Services programs when possible.

Certain services and clients of the Department of Human Services qualify for funding under the Medicaid Program. Some of the programs that receive Medicaid funding are: the Utah State Hospital, the Utah State Developmental Center, Home and Community based waivers in the Divisions of Aging, Services for People with Disabilities, and Family Services.

The General Fund for these services is appropriated to the various divisions of the Department of Human Services who then "seed" or purchase federal funds through the Division of Health Care Financing. The agencies seeding Medicaid are able to purchase more or less than the amounts appropriated depending on available General Fund, qualifying programs and clients, and the priorities of the program. The Analyst has based his recommendation on the amount of funding requested by the divisions in the Department of Human Services.

3.3 Medical Assistance - Utah Medical Assistance Program (UMAP)

Recommendation The Analyst recommends an appropriation for $6,785,900 for the Utah Medical Assistance Program (UMAP).

If a recipient is deemed Medicaid eligible after services have been provided, Medicaid will be billed and pay for the services. Because this happens frequently, Federal funds and Revenue transfers (from the Medicaid program) are included in the funding schedule.

3.3 Funding

Plan of Financing	FY 1998 Actual	FY 1999 Estimated	FY 2000 LFA	Difference Est./LFA
General Fund	$3,232,200	$3,258,900	$3,258,900	$0
Federal Funds	2,080,748	1,700,000	2,080,700	380,700
Revenue Transfer	1,446,317	1,511,700	1,446,300	(65,400)
Beginning Non-Lapsing	49,850	0	0	0
Total	**$6,809,115**	**$6,470,600**	**$6,785,900**	**$315,300**
% Change		(4.97%)	4.87%	
FTE	37.3	51.5	51.5	0.0

Summary The Utah Medical Assistance Program (UMAP) is designed to serve individuals who cannot qualify for Medicaid or Medicare. Funding for UMAP is from the General Fund.

Eligible individuals are ages 19 through 64. They must have income which is no greater than $50 above the Basic Maintenance Standard (BMS) for the size of household. (The BMS for one person is $337 per month). Allowable assets are limited to $500 for a one-person household.

In FY 1998, there were approximately 10,000 eligible recipients, of which 5,276 received covered services. Coverage is limited to medical conditions that are acute, life-threatening, or contagious to the general public. Among conditions

that are excluded are psychiatric conditions, chronic conditions, and conditions which arose during the commission of a crime or while incarcerated. Inpatient hospital services are not a covered benefit of the program (in-state hospitals donate care when the service is otherwise a UMAP covered benefit.) All services covered by UMAP must be pre-authorized before payment.

Eligibility is determined by the Bureau of Eligibility Services, or the Department of Workforce Services. Eligibility can be established back to the first of the month 30 days prior to the month of application.

UMAP is the payer of last resort.

4.0 Tables: Medical Assistance

Plan of Financing	FY 1996 Actual	FY 1997 Actual	FY 1998 Actual	FY 1999 Rev. Estimated	FY 2000 LFA	Difference Est./LFA
General Fund	$120,575,600	$127,889,700	$133,317,800	$136,852,600	$145,626,500	$8,773,900
Federal Funds	440,103,469	463,094,517	479,124,916	490,713,300	512,675,700	21,962,400
Dedicated Credits	18,821,502	21,223,867	32,173,717	33,799,800	32,582,100	(1,217,700)
GF Rest. - Medicaid Hospital Provic	9,610,400	7,345,300	6,335,900	0	0	0
GF Rest. - Medicaid Restricted Acc	0	0	1,750,000	3,439,000	5,588,700	2,149,700
GF Rest. - Nursing Facility Account	3,531,300	3,579,200	3,681,700	4,244,800	4,042,900	(201,900)
Revenue Transfer	23,111,175	28,446,168	33,894,858	31,286,000	30,944,400	(341,600)
Beginning Non-Lapsing	312,200	49,850	49,850	134,500	0	(134,500)
Closing Non-Lapsing	(49,850)	(49,850)	(134,529)	0	0	0
Lapsing	(7,410,987)	(8,947,431)	(8,042,375)	0	0	0
Total	**$608,604,809**	**$642,631,321**	**$682,151,837**	**$700,470,000**	**$731,460,300**	**$30,990,300**
Programs						
Medicaid Base Program	$518,904,691	$539,523,484	$572,021,470	$590,678,100	$621,353,100	$30,675,000
Title XIX Funding for Human Servi	85,133,600	97,004,112	103,321,252	103,321,300	103,321,300	0
Utah Medical Assisstance Program	4,566,518	6,103,725	6,809,115	6,470,600	6,785,900	315,300
Total	**$608,604,809**	**$642,631,321**	**$682,151,837**	**$700,470,000**	**$731,460,300**	**$30,990,300**
Expenditures						
Personal Services	$564,608	$1,583,881	$1,841,820	$1,947,900	$1,954,800	$6,900
Travel	6	409	3,210	2,800	2,800	0
Current Expense	282,244	342,167	418,575	406,200	406,600	400
Data Processing	1,950	1,650	6,105	27,200	27,200	0
Pass-Through	607,756,001	640,703,214	679,882,127	698,085,900	729,068,900	30,983,000
Total	**$608,604,809**	**$642,631,321**	**$682,151,837**	**$700,470,000**	**$731,460,300**	**$30,990,300**
FTE	26.00	35.00	37.33	51.50	51.50	0.00

4.1 Federal Funds: Medical Assistance

	FY 2000 LFA
Medical Assistance	
Title XIX	$436,224,300
Medicaid Administration	
Medical Assistance	
Seeding	74,370,700
Medical Assistance	
UMAP	2,080,700
Total	**$512,675,700**

4.2 Definitions: Medical Assistance Categories of Service

Aging Waiver	The aging waiver allows state Medicaid agencies to cover services not otherwise available under Medicaid to individuals 65 and over, who would be in an institution without these services. This allows these older adults to retain some level of independence and a greater quality of life by enabling them to remain in their own homes.
Ambulatory Surgical	Surgery on an ambulatory basis is provided.
Case Management Fees	Payments made to local health departments for case management services.
Child Health Evaluation and Care (CHEC/EPSDT)	Screening, diagnostic, health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered in recipients under age 21. Utah's version of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment program.
Chiropractic Services	Services which involve manipulation of the spine that a chiropractor is legally authorized to perform under state law.
Contracted Mental Health Services	Mental health services provided to children in foster care and under the authority of Division of Family Services/Division of Youth Corrections (DFS/DYC) are eligible for reimbursement effective 7/1/93. These services must be provided by a provider under contract with DFS/DYC. DFS and DYC will provide the state match for these services.
Dental Services	Diagnostic, preventative, or corrective procedures provided by a dentist in the practice of his/her profession.
Early Intervention	Diagnostic and treatment services to prevent further disability and improve the functioning of infants and toddlers (up to age four) with disabilities. The program is administered by Family Health Services which contracts with providers consisting of multi-disciplinary teams of health care professionals who work with the family to evaluate and coordinate services to ensure that the needs of the child are met.

Group Pre/Postnatal Education	Classroom learning experience for the pregnant woman with the objective of improving knowledge of pregnancy, labor and childbirth, informed self care, and preventing development of conditions which might complicate pregnancy. Infant, feeding, or parenting classes may also be included.
Health Maintenance Organizations (HMOs)	Basic medical and dental covered services provided by health maintenance organizations.
Home and Community-Base Waiver for Developmentally Delayed/Mentally Retarded (DD/MR)	Provides services within the community to a limited number of individuals who meet criteria established for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) services. The State may provide waivered services, including residential treatment, day training, respite care, family support, and case management.
Home Health Services/Hospice	A program of intermittent and part-time nursing care provided in the patient's place of residence as an alternative to premature or inappropriate institutionalization.
Inpatient Hospital	A required service that provides medically necessary and appropriate diagnostic and therapeutic services for the care and treatment of injured, disabled, or sick people who must remain in the hospital for more than 24 hours.
Inpatient Hospital Mental - Mental Youth and Aged	Mentally ill, youth and aged clients in an inpatient hospital setting, requiring constant care.
Intermediate Care Facilities	Intermediate care facilities offer care to chronically ill patients.
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)	Intermediate care facilities catering to mentally ill clients requiring less care than an inpatient hospital patient.

ICF/MR Day Treatment	Day treatment is provided to intermediate care and mentally retarded individuals.
Kidney Dialysis	A program for people who have irreversible and permanent end-stage renal disease and require a regular course of dialysis.
Lab and Radiology	Laboratory and radiological services are provided for the client.
Medical Supplies	Medical supplies necessary for treatment are provided to individuals who require them.
Medical Transportation	Transportation is provided to and from medical appointments and treatment when needed.
Mental Health Services	These include the continuum of mental health services provided by the 11 community mental health centers, including the three prepaid mental health clinics. The county mental health authorities provide the state match for these services.
Nutritional Assessment/ Counseling	Service provided by a dietician for pregnant women with complex nutritional, medical, or social risk factors identified in early prenatal visits and referred for intensive nutritional education, counseling, and monitoring for compliance and improvement.
Occupational Therapy	Occupational therapy is provided to needy individuals to assist them in returning to the work force.
Optical Supplies	Services which include lenses, frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist to the extent permitted under state law.
Outpatient Hospital	A required service that provides medically necessary diagnostic and therapeutic services ordered by a physician or other practitioner of the healing arts. These services must be appropriate for the adequate diagnosis and treatment of the patient's illness.

Pediatric/Family Nurse Practitioner	Registered nurses with specialty training and certification, licensed within the State to provide general and preventive services within a specific specialty as authorized by licensure within the State. See specialized nursing above. (Coverage of these practitioners is mandated.)
Perinatal Care Coordination	Targeted case management for pregnant women. Services are provided to a woman with a medically verifiable pregnancy who is a Medicaid client or who meets the financial requirement for presumptive eligibility to receive ambulatory prenatal care services. The purpose is to coordinate care and services to meet individual needs and maximize access to necessary medical, social, nutritional, educational, and other services for the pregnant woman throughout pregnancy and up to the end on the month in which the 60 days following pregnancy ends.
Personal Care Services	The personal care services program enables recipients to maintain a maximal functional level in their place of residence through providing minimal assistance with the activities of daily living.
Pharmacy	Drugs prescribed by their respective physicians are provided to individuals which are required for treatment.
Physical Therapy	Services prescribed by a physician and provided by a physical therapist.
Physician Services	"Physician services", whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician, (1) within the scope of practice of medicine or osteopathy as defined by state law and (2) by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.
Podiatry Services	Services provided by a podiatrist who is licensed under state law to render medical or remedial care for the foot and associated structures.
Pre/Postnatal Home Visits	Home visits are part of the management plan for a pregnant woman. The visits are for the purpose of assessing the home environment and implications for management of care, to provide emotional support, determine educational needs, provide direct care and encourage regular visits for prenatal care.

Pre/Postnatal Psychosocial Counseling	Evaluation to identify families with high psychological and social risks and follow up to develop a plan of care to provide or coordinate appropriate intervention, counseling, or referral necessary to meet the identified needs of families.
Private Duty Nursing	Nursing service provided in a client's home for up to 24 hours per day as an alternative to prolonged hospitalization or institutionalization of technology dependent individuals. This option, when compared to other alternatives, must provide quality and cost effectiveness over the long term, and requires participation of family members in the care during hours when nurses are not present.
Psychologist Services	Licensed psychologists may provide evaluation and testing to individuals with a diagnosis of delayed development (DD) or mental retardation (MR), early periodic screening diagnosis and treatment (EPSDT)-eligible Medicaid recipients and to victims of sexual abuse. They may provide individual, group, and family therapy to those eligibles. The Department of Human Services provides the state match for services provided to the Division of Family Services (DFS) and the Division of Services to People with Disabilities (DSPD) clientele. Psychological evaluation and testing for Medicaid clients who exhibit mental retardation, developmental disabilities or are victims of sexual abuse and are eligible for EPSDT.
Rural Health Services	Health services are provided to individuals who live in rural areas.
Skilled Nursing Facilities	Skilled Nursing Facilities offer skilled nursing care to chronically ill patients.
Skills Development	Medically necessary services to improve and enhance the health and functional abilities of the children ages 2 to 22 and prevent further deterioration. Services include individual or group therapeutic intervention to ameliorate motor impairment, sensory loss, communication deficits, or psycho-social impairments and skills training to the family to enable them to enhance the health and development of the child. Services are identified in the child's I.E.P. and provided by or under the supervision of specified licensed practitioners.

Specialized Nursing Service	The following specific practitioners are covered as Medicaid providers. Services of nurses practicing within a specialty area to the extent of licensure within the state. Four groups currently have provider status: 1. Certified Registered Nurse Anesthetists (CRNA) 2. Certified Registered Nurse Midwives (CNM) 3. Certified Family Nurse Practitioners (CFNP) 4. Certified Pediatric Nurse Practitioners (CPNP)
Specialized Wheel Chairs	Special wheel chairs are provided to needy individuals.
Speech and Hearing	Diagnostic, screening, preventive, or corrective services provided by a speech pathologist or audiologist for which a patient has been referred by a physician.
Substance Abuse	Treatment is given to clients for alcohol and drug abuse and misuse.
Targeted Case Management	Targeted case management services designed to assist an individual in a targeted group to gain access to needed medical, social, educational, and other services. In Utah, there are several targeted groups which assist individuals in the groups in planning, coordinating, and accessing needed services.
Targeted Case Management for AIDS	A set of planning, coordination, and monitoring activities that assist recipients in their target group to access services.
Vision Care Services	Diagnostic, screening, preventive, or corrective services provided by a physician skilled in disease of the eye or an optometrist to the extent permitted under state law.